

February 2, 2009

These comments are on behalf of the California Applicants' Attorneys Association concerning the revised report by the Lewin Group regarding adopting a Resource-Based Relative Value Scale for the physician fee schedule.

As noted in our letter to Dr. Searcy (May 20, 2008) regarding the original draft of the Lewin report, our main concern is that the adoption of a new physician fee schedule must not reduce an injured worker's ability to secure prompt and appropriate medical treatment. Unfortunately, without careful attention to how a conversion to an RBRVS-based schedule impacts all physicians, we believe that the end result could be a disruption in the marketplace that would harm both workers and employers.

According to the Lewin report (First Report, Revised, page 5),

"Among all 50 states, CWCS payment rates are among the lowest. [Footnote omitted.] In 2006, California ranked sixth from the bottom for all services. This low ranking applies to both surgical and E&M services."

The Lewin report also shows that under a budget-neutral, single conversion factor change, surgeons' fees would be reduced by -12.1% (Figure ES-B, page 4), and that overall payments for surgical services would be reduced by -26.3% (Figure ES-A, page 3).

As demonstrated in a number of studies that have been provided to the Division, other states that adopted RBRVS-based fee schedules experienced significant declines in physician participation. We believe that the only possible consequence of slashing average surgical fees by -26.3% would be a similar exodus of many of the best and most qualified physicians and surgeons from our workers' compensation system. This is particularly true considering that this -26.3% reduction is an average and, while further details are not provided in the Lewin report, it is certain that some services and physicians will see reductions considerably higher than that average figure. The impact would not only cause access problems for injured workers, but would increase costs to employers as necessary treatment – and therefore return to work – is delayed. This is simply unacceptable, and we do not believe this is the goal of anyone in the system, including the Division.

As noted, the above figures from the Lewin report regarding the reduction in fees in certain categories are based upon adoption of an RBRVS-based system with a single conversion factor. According to the report, "[a] single conversion factor would maintain relativity between CPT codes." (First Revised Report, page 2) While this is correct, there is no explanation of why the California workers' compensation system should use the same relativities as Medicare. In fact, the Lewin report examined fourteen other states, nine of which use an RBRVS-based physician fee schedule, and only two of those states use a single conversion factor for their workers' compensation fee schedule (and therefore use the same relativities as Medicare).

As noted in our May 20, 2008 letter to Dr. Searcy, the differences in patient population and even the basic goals of the systems between Medicare and workers' compensation clearly indicate that incentives and payment patterns should be different. We therefore strongly support the alternative offered in the Lewin report to adopt more than one conversion factor. We believe this is imperative to assure that any disruption caused by adoption of an RBRVS-based fee schedule is minimal.

We continue to look forward to working with the Division and other parties in the system to make certain that modifications to the physician fee schedule further the ultimate goal of assuring that injured workers are able to receive appropriate and necessary medical treatment in a timely manner.

Leonard Okun, M.D.
President
U.S. HealthWorks Medical Group

February 2, 2009

As President of U.S. HealthWorks Medical Group, I am pleased to post comments on the Division's Forum concerning the recently released Lewin study: "Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule First Report, Revised".

U.S. HealthWorks strongly supports updating the current Fee Schedule using a Resource Based Relative Value Scale (RBRVS) methodology. Such a conversion will more appropriately allocate resources amongst providers, and will follow changes made in many other states that now successfully use such methodology for workers' compensation fee schedules.

I anticipate the Division will study other states' reimbursement models, including the Conversion Factors (CFs) used, and the use of one or more CFs. Such study will show how terribly inadequate provider reimbursement in our state currently is. It is clear that California lags other states in fairly compensating occupational physicians for the specialized care we provide to the injured worker, and the disability management services we perform to manage early return to work, case closure, and total case cost.

The Revised Lewin study calculates an even ***lower*** effective CF than the May report outlined. Lewin uses an assumption of budget neutrality, with the most recent CF of \$44.19 versus the May CF of \$44.57. ***The effective median CF for all other states is close to \$60!***

The Revised study again outlines how truly bleak compensation for providers is: "Among all 50 states, CWCS payment rates are among the lowest" (page six). ***This in a state where practice costs are typically the highest!***

In previous communications to the Division, I have presented significant supporting data that strongly argues for immediate and fair physician reimbursement, at least to the levels seen in

other states. I will not reiterate those arguments here, except to say that time is of the essence. Providers are undercompensated and have been for many years. The E&M increase two years ago, although welcome, did virtually nothing to alleviate poor reimbursement due to the erosion of inflation and changes made in other physician services.

Our clinical model that combines excellent clinical care and careful case management is world class, and we can show it both in terms of quality care and case cost. Such *value*, however, comes at a cost, and now is the time to both recognize that fact and fairly compensate all providers in California.

The revised Lewin study describes in detail the methodology used to convert reimbursement for services to a RBRVS based system. However, the study does not recommend policy decisions, and that is unfortunate, given that throughout the text there are multiple examples of much better (and fairer) reimbursement structures in other states. I do understand, however, that policy decisions are the domain of the Division, and not an outside consulting group.

The study does, however, pose five very relevant questions for policy makers (page 75). From someone who has practiced in the California workers' compensation system for decades, and now is President of the largest California medical group that provides specialized occupational medicine services, I would like to offer the following recommendations to the Division in response to the Lewin questions:

1) How quickly should the RBRVS be implemented? If there is a transition, should it be at the service category level (e.g., surgical vs. E&M) or at the code level?

Thoughtful implementation of a RBRVS based system will require input from various stakeholders, and necessarily take time. The Medical Group supports an immediate transitional step of increasing E&M codes to the \$44.19 level presented in the revised study.

2) At the end of the transition, will it be necessary to preserve physician participation in the system by having multiple conversion factors, in particular, higher factor for surgical services?

The Medical Group supports the development and implementation of at least two conversion factors, perhaps one for E&M services, and others as needed (for example, a separate conversion factor for surgical services).

3) Should the RBRVS payment reflect geographical differences in the cost of service delivery or in physician shortages?

The Medical Group is already experiencing physician shortages. Using the Geographic Practice Cost Index (GPCI) may perversely lead to lack of provider participation in rural or underserved areas. The Medical Group would not support a system that may negatively impact provider participation in rural areas.

4) How should the conversion factor be adjusted over time?

The Medical Group supports a conversion factor (or conversion factors) set at the median of all states. Subsequent to that, annual adjustments should be made relative to changes in a commonly used index, such as the Consumer Price Index (CPI), or to changes in the median conversion factors of all states.

5) Finally, should the new system be budget neutral to the current OMFS payments?

The new system cannot be budget neutral, as physicians have been enduring years of inadequate reimbursement in our state. That is a fact, and I look to the Division to support providers gaining a reimbursement structure that is more fair and acknowledges the value specialized occupational medicine brings to workers and businesses alike. The Medical Group would support the Division in cost cutting efforts elsewhere where services, such as utilization review and fees for other, avoidable, middleman services, are neither helpful or contribute positively to patient care. Once again, I am thankful for an opportunity to comment in the Forum. I am willing to assist the Division in any way I can to expedite progress in the conversion to a new provider payment system.

Stephen J. Cattolica
Director of Government Relations
Advocal

February 2, 2009

On behalf of our clients, the California Society of Industrial Medicine and Surgery and the California Society of Physical Medicine and Rehabilitation, we thank the Division for this latest opportunity to contribute to the outcome of a much needed update to the Official Medical Fee Schedule (OMFS).

Over the past four years, the Division has become aware of what can be expected from a conversion of the present OMFS to one based on the Medicare-RBRVS system. Results from similar initiatives undertaken in 19 other states suggest quantitatively that, depending on the exact circumstances present in each jurisdiction, to a greater or lesser degree the medical delivery system deteriorated. This caused rapid implementation of rescissions, revisions and corrections to reestablish appropriate access to injured worker care.

We thank the Division for its stated dedication to avoiding a similar outcome in California. We recognize that the present Lewin Study is a revision of the first one published in May 2008. As such, we are disappointed that this latest edition provides the community with none of the information that was requested during public meetings at that time. There is virtually no new information or guidance for individual physicians trying to understand the impact of a RBRVS based OMFS on their specific practices.

Broad groupings of disparate provider types and resulting average changes to reimbursement provide little or no useful information for the Division or for stakeholders to understand what the actual changes in reimbursement levels might be.

Therefore, we must request once again that the Division provide analysis and tools that physicians active in occupational medicine in California, can use to determine the impact of a

conversion upon their specific practices. We refer to our testimony provided in May 2008 for this purpose.

Unavoidably, the Division and stakeholders have been marking time. We respectfully suggest that the Division begin stakeholder discussions about the fee schedule's Ground Rules in the coming weeks so as not to waste any additional time. While financial modeling and the Ground Rules for use of the OMFS go hand-in-hand, a number of basic decisions can be discussed and sound decisions made or reaffirmed.

These two activities can and should move forward concurrently.

Peter Mandell, M.D., Chair
Workers' Compensation Committee
California Orthopaedic Association

February 2, 2009

Thank you for giving us the opportunity to review the revised report from The Lewin Group entitled, "Adapting the RBRVS Methodology to the California Workers' Compensation Physician Fee Schedule.

From comparing the revised report to the initial report, we see that the percent change in payment from the adoption of a budget neutral baseline RBRVS Model has changed both for the service category and the specialty category. The report does not document why the change was made nor does it supply the back-up documentation to understand the calculations.

Our fundamental concern, however, with the report is that it continues to group all surgical procedures into one category "surgery." This one category is too broad for the data to be meaningful to any one surgical specialty. It is misleading for the report to declare that a budget neutral transition to RBRVS with a conversion factor of \$44.19 would result in a -26.3% reduction in reimbursement for surgical procedures.

In fact, COA has calculated the impact on commonly performed orthopaedic codes. We found the following:

	CF \$44.19	CF \$60.18
29826 – Shoulder Arthroplasty	- 47.93%	-29.09%
29880 – Knee Arthroplasty	- 50.26%	-32.26%
63030 – Low Back Disk Surgery	- 44.62%	-24.58%

In addition, surgeons will see reduced reimbursement for x-rays and MRIs performed in their offices.

With conversion factors of \$44.19 or \$60.18, the reductions will be much more substantial on individual orthopaedic practices than projected by the Lewin Report. Such reductions would

imperil injured worker access to rapid, high-quality orthopedic care. For many musculoskeletal injuries, rapidly accessible care is a key to improving function and returning employees to work quickly.

As you know, these reductions would be on top of:

- A 5% reduction in 2004.
- No increase in reimbursement since 1985.
- Cost-of-living increases of 74% since 1985.
- California reimbursement rates the sixth lowest in the nation.
- Other states paying surgical fees at about twice the Medicare reimbursement levels.

Without a code-by-code analysis, it is impossible for the Division to have a true sense of the impact on various specialty practices. We continue to urge the Division to request a code-by-code analysis from The Lewin Group. This analysis should contain the relative unit values used by Lewin for the calculations.

On the other hand, we support provisions in The Lewin Report which discusses an update to the latest CPT codes, annual cost-of-living increases, and the use of multiple conversion factors.

We would be open to discussing with you an incremental approach in updating the fee schedule so that issues that are less controversial could move forward and be implemented providing more clearer communication as to the services rendered and billed.

Kamal Eldrageely, MD

January 30, 2009

I am an MD treating patients in California workers compensation system. Over the years, provider costs have risen like any other business yet we are precluded from adjusting fees due to the OMFS.

Overall work comp costs for employers and insurers have drastically been reduced by ACOEM, UR, the PD rating schedule and caps on PT, OT and chiropractic. Primary care providers, acting as gatekeepers, help control costs. E&M, medicine, lab and rehab (PT) fees need to be increased in order to insure the survivability of good occupational medical providers. I urge passage of the RBRVS under the Lewin report to happen on or before June 1, 2009.

Thank you.

Dr. Jones

January 30, 2009

As a medical provider treating primary care patients in Californian for over 20 years, I support the long overdue changes to the OMFS.

My labor costs, insurance, rent, healthcare and supply costs have gone up over the past many years and we have had no corresponding adjustment to the OMFS. There was SB 228 which reduced our fees, pharmacy reimbursement adjustment and lab reduction. A venipuncture went from \$15.30 to \$3.00!!

Now is the time for the adjustment on fees especially for the providers in the system who are helping to contain costs and reduce indemnity expense. Please make this happen in April 2009 or soon thereafter.

Larry Cate

January 28, 2009

After reading the Lewin Group report, the option of adopting multiple Conversion Factors based on medical specialty appears to undermine the very foundation of the factoring used in RBRVS, especially as a means to satisfy a small sector of the medical community (i.e. surgeons and neurologists). Should a form of enticement be necessary to keep some providers in the workers' compensation system, it would seem far more reasonable to create a number of geographic regions that adjust the CF based on the barriers to health care delivery (i.e. cost of doing business, competition, scarcity of providers, etc...).